Information Exchange Workgroup
Draft Transcript
April 28, 2011

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you very much. Good afternoon, everybody and welcome to the Information Exchange Workgroup. This is a Federal Advisory Committee, so there will be opportunity at the end of the call for the public to make comments. A reminder to Workgroup members to please identify yourselves when speaking. And let met do a quick roll call. David Lansky.

David Lansky – Pacific Business Group on Health – President & CEO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Micky Tripathi. Carl Dvorak.

Carl Dvorak – Epic Systems – EVP
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Connie Delaney. Gayle Harrell. Deven McGraw. Paul Egerman.

Paul Egerman – Software Entrepreneur
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Jim Golden. Dave Getz. Jonah Frolich. Steven Stack is on, but he's on mute. George Hripcsak.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Seth Foldy. Jim Buehler could not make the call today. Walter Suarez.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
David Roth. Hunt Blair also could not dial in. George Oestreich. Jessica Kahn. Tim Andrews. And did I leave anybody off? All right, I'll turn it over to Dr. Lansky.

David Lansky – Pacific Business Group on Health – President & CEO
Thank you. I think we're hoping we can get some form of this letter back to the Meaningful Use Workgroup for its consideration and it begins another round of meetings next week. So, with luck out of today's discussion we can settle on something we're comfortable transmitting to them the next day or two.

So, I hope given everyone has now had time to go through it pretty carefully and we've had quite a few very substantive comments, we can either decide to adopt those comments or where we see there are

variations in opinion, find an elegant way to create to the Workgroup, the Meaningful Use Workgroup, what the range of feeling is among our folks and how we would advise them in resolving some of the things that may be as yet unresolved.

I know I'm feeling, and I think Micky has indicated as well, that we haven't had as much time as we'd like to wrestle with some of the more challenging developmental opportunities that the program gives us in the area of information exchange and I think as you go through these comments we'll see a number of areas where we've all felt we want to get to the goal, but we haven't quite agreed on how we do it. So, hopefully, we can find a way to communicate something constructive to the Meaningful Use group.

And Cory did some very good work to try to incorporate a number of comments into this current draft, which I think Judy sent out to everyone this morning. And it did occur to me that there is that last section in the letter, Stage 2, Stepping Stones for Stage 3 that may give us a template of some kind that we can work from in areas where we don't have a clear consensus position, which is to suggest to the Meaningful Use Workgroup the issues or problems that they might encourage various groups to solve over the next year or two where we don't have agreement yet as to how we think the right answers look. So, I'll just put that out there for us to think about.

Deven McGraw – Center for Democracy & Technology – Director
This is Deven and I'm sorry I'm late. I just joined.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
And hi, David. This is Micky as well. I'm on.

David Lansky – Pacific Business Group on Health – President & CEO
Great. So, I think the best thing for us to do, given our goal in the next hour or so is to see if we have a letter we can transmit and if there are some adjustments we can make to this draft let's at least scope them and then work with staff to get this to final.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
David, this is Walter. I just want to comment; I think on the agenda there is also the finalizing of the recommendations on the IL Provider Directory.

David Lansky – Pacific Business Group on Health – President & CEO
Yes, maybe, Walter, you and Micky, can you suggest how much time we need for that and whether we should do it now, if it's brief or do we hope to have time at the end, which is not very likely.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes, I think what Cory had said is we'll try to hit up, because I think we've done one turn in the presentation and we didn't push hard in getting comments back from the Workgroup on that, so I think by, I forget what Cory had set as a deadline, but by the end of today or tomorrow we'll send it out to the Workgroup, get some feedback. So, maybe just having a parallel offline process to get the feedback on that to prepare us for May 11th is what we were thinking there.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
And, David, this is George. Just so you know, this morning we had our Meaningful Use call. People are going to be working on HIE patient care coordination over the weekend for a Monday morning Meaningful Use meeting. So, even if the letter is not finished, if a draft could go over so we could share it with them would be helpful, to someone like Christine Bechtel, that kind of thing.

David Lansky – Pacific Business Group on Health – President & CEO
George, can you say any more about the nature of the discussions in that Workgroup this morning on the subjects of interest to us?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Yes. We did not work further on a patient engagement and we kind of wanted your input before we started working on that. Remember, we did our RFC, we got the information back. We had already gone once through patient engagement. We want to go through a second time. There was a ceiling that Paul expressed about simplifying things and we wanted your input on that. Christine is going to be working on that tomorrow and over the weekend.

On care coordination, David Bates led that one, so we just went through that today, but if there are going to be any modifications we'll need that on Tuesday. And Art Davidson did a lot of work today on the public health, which you have comments on and he's supposed to come back with a more concrete description over the weekend for us on Monday morning.

David Lansky – Pacific Business Group on Health – President & CEO
Well, I guess I'd welcome any advice on how best to leverage and synchronize the work of these different groups and experts. I think we're feeling a little bit unconnected to very important and related conversations. But I don't want us to spin our wheels here.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
If I had thought about it, I would have asked Judy to send a reminder to the IE Workgroup that they should at least listen in on the Meaningful Use Workgroup today, but there will be an opportunity to listen in on Monday, because it's a public thing and listen in on Tuesday, whoever wants to; that's all day.

But whatever discussion you have, even if it's not decided and you state in this letter that we haven't decided this, but here are some thoughts, is still useful to Christine and Art.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
George, this is Walter, and I was actually listening this morning to the very rich discussion. I do believe that there are a number of items in our recommendations from the first letter as well as from the letter that we will be talking about at this meeting that would be very important to communicate to the leads of each of the groups, particularly in the, for example, the public health side we had some specific recommendations that it's important to pass to Art Davidson as soon as we're done with the call because they're going to be working, as you said, on the recommendations for Monday.

As well as the care coordination one, which includes the HIE recommendations and some of the other things that we had in the letter, so I think it's going to be helpful to send it, the first letter as well as this new second letter in whatever form we have by the end of the meeting today, to the various leads of the groups that are developing the final recommendations to present next week.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I think that's an excellent suggestion. What I would suggest is we have Judy send out whatever materials you're willing to, send that to the entire Workgroup, but if someone could actually talk to the three leads, which would be Art and Christine being the most important, but also David Bates for leading the care coordination one. If someone could actually talk; I mean, an email could be talking, but a personal letter to them saying here's the key things to look at in our letters, or here's where we think we're not going right, that would really do a lot to help coordination.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I'll be happy to communicate with Art Davidson on the public health side.

Seth Foldy – Wisconsin – State Health Officer
Yes, Seth Foldy, I'll work with Walter and Art on that as well.

David Lansky – Pacific Business Group on Health – President & CEO
All right, well thank you. As far as the other ones go I can certainly talk to Christine.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
And those are the two who are going to do the work over the weekend I believe.

David Lansky – Pacific Business Group on Health – President & CEO
Okay. Is the care coordination work fairly set, George?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
We came to decisions, but talking to David Bates is never a bad idea.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay, I'm happy to do that. This is Micky.

Deven McGraw – Center for Democracy & Technology – Director
And this is Deven, George, I'm on, too. I actually think that we had some discussion today on the care coordination recommendation that the IE Workgroup had already talked about, which is to sort of look at exchange not from the perspective of advancing the perform a test from Stage 1, which we clearly didn't want to do or even to go to the point of saying, you know, exchange with just one or three providers, but instead looking at taking an existing exchange requirement, like the care summary and putting a threshold for some of that to be electronic, with part of the discussion today.

I don't know that we've set the percentage threshold at the same level; we might have lowered it a little bit from where the IE Workgroup recommended it, but where people were favorable to approaching the exchange issue from that context.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I agree 100%. And by the way, I didn't mean to say it's set in the sense of we're done. Today is the day when we're going to step back and look at this whole thing. So, nothing is set in the sense that we're finished with. I just meant he said he's not working on it this weekend necessarily.

David Lansky – Pacific Business Group on Health – President & CEO
Okay, well let's jump into the context here and it sounds like we will take the results of this and through at least three channels make sure that there is coordination over the next few days with the Meaningful Use Workgroup, subgroups, and as we all get to a consensus working document we can then all review the whole, hopefully, in the next couple of weeks.

So, let's go through the main topics. I think some of them are on the slides and, hopefully, you all have a copy of the current draft letter. And so on ILPD, Micky, we're okay. We're just going to do that offline from here.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes, I think we'll do that offline.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Can I just say one word very quickly on the ILPD because tomorrow the Security & Privacy Workgroup of the Standards Committee is going to be meeting and I was going to be providing a quick overview of the draft of the ILPD recommendations the way we had them?

The last document I have is the one that Judy submitted to this group back on April 15th, which was the revisions that were made to the previous presentation. So, that's the latest version that we have at this point, right?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Yes, that's the latest version.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
And I should emphasize I have sent a couple of emails about this, but there is a critical path around provider directories that I was hoping that we were going to try to finish up those today, but certainly by May 11th because the Security & Privacy Workgroup of the Standards Committee has to deliver recommendations on the Provider Directory to the Standards Committee by May 18th.

So, that's why there is an urgency in trying to certainly get the ILPD policy recommendations on this and that's why I was sending messages about bringing this up to this meeting, but certainly the priority here is the Meaningful Use letter.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Well, all of it, Walter, will be gated by that May 11th meeting anyway because anything we decide here, obviously, needs to be approved by the Policy Committee before anything is passed over, so I don't think it slows that process down.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Well, we were going to start work on it as soon as this group was even in preliminary form, but anyway.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay, well, offline if you have any particular things that you think maybe that doesn't address, but that would be helpful to your Workgroup on the Standards Committee side, maybe a couple of emails as well.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I will bring up that, sure.

David Lansky – Pacific Business Group on Health – President & CEO
Thanks. So, let's go on to the first two items are patient view and download information and electronic copy of discharge instructions and several comments came in over the last week questioning, largely as I understood it, some of the security implications of that and the potential for problems if, for example, USB sticks are the preferred medium and that either creates a burden on the providers to encrypt the data on a USB stick or it creates an exposure inadvertently to the patient of some risk.

So, I heard a couple of people recommend that we go back to the portal proposal that we had originally had. So, there are two schools of thought on this. I guess we should just open it up for discussion now to see if we can have an agreement. One solution would be to add a term like encrypted to the non-portal platforms, but another would be to either retain it as is, go back to the original portal proposal or simply describe the problem and let the Meaningful Use group sort it out.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
This is Steve Stack and I'm sorry if the airport announcements intrude. I like the way you guys have the language here. I've missed the last two calls due to conflicts, but I like the flexibility you've provided in here. Even if you encrypt it and you give it to the patient. If they put it in their own PHR and then they decide to put it on their own FEM drive and take it somewhere, I mean ultimately they become the steward of that information and responsible for it.

So, I think we run the risk of over-designing a system and boxing out flexibility that will make it adapt in better ways than we can currently anticipate. So, I would rather we leave the language you all currently have here, which I think is much more flexible for the future.

Carl Dvorak – Epic Systems – EVP
This is Carl. I definitely agree with that. We've already got people now with an iPhone app for their personal health records. So, it's not really a Web-based portal; it's not really USB stick or a CD, it's just its own new class of things and patients seem to love it.

Deven McGraw – Center for Democracy & Technology – Director
I was one of the people that raised a concern with the language and I understand the technology lock in argument, but here's what I don't like so much about the options of secure email or the use of a USB stick, which in addition to security issues with portable media, my other concern is that what I liked about the portal was the concept of a view and download into some portion of an EHR that wouldn't require a lot of additional work on the part of the provider to do.

So, again, we've got a lot of places in Meaningful Use where patients get things if they ask for it and certainly with respect to even your right to an electronic copy under HIPAA, you might put that on a USB stick and whether it's secure or not, absolutely when the patient takes custody of it, regardless of how she gets it, the responsibility is on the patient to handle it responsibly, etc. Getting it by email makes sense versus some sort of automated capability and the functionality that gets built into systems to allow that to happen so that it's not dependent so much on people making time to prepare it versus some automated functionality in the system where people have easy access to it on their own time. It doesn't depend on necessarily having an e-mail account that's not at your employer, for example, etc.

So, I just wonder. I mean, I don't like the way it's currently phrased. If we want to achieve consensus on something then I'd much prefer that we try to work on some language that raises concerns about locking in a particular technological approach to this, but acknowledging that what we want to find is an easy mechanism for patients on their own time to be able to get a view and download of certain parts of their health record consistent with what's already in Meaningful Use for what we want to expose to patients, that they are then able to turn around and use in whatever way we want to.

So, in terms of the point about sort of we can't predict where the technological mechanisms go, I wholeheartedly agree. We have no idea what's going to be the next great thing in this regard, but we first have to solve for getting the information out of the EHR in the first place. And that's where I'm looking for something that is fairly reliable and consistent and ideally could be built in through certification and I don't necessarily want to let the portal go, necessarily, if that is the vehicle that makes the most sense for this period of meaningful use, which is a limited snapshot in time.

Paul Egerman – Software Entrepreneur
This is Paul. I agree with what Deven just said. I have the security concerns about the USB thumb drives. The more practical concern is I go to my physician, I say I want my data in an electronic form and they say here's a thumb drive and I say, well, I don't know how to use that thing or I don't have a machine that uses that. I really would just like to look at it on my screen. The physician can say, no. This is all we do is we do the thumb drives.

To me, that just doesn't work. I think you do need to have the ability to view the data and the ability to download it. I learned that the word download means different things to different people. To me, download means you can actually transfer some data from the EHR system to the possession of the consumer, the patient; that's what a download is.

And so to respond to Carl's comment about maybe the term Web portal is too limiting. We could fix that, I think, by saying an electronic view or a way to see electronically what the data is without necessarily specifying it's the Web, although I think most mobile devices probably do use the Internet. But you could drop the word Web, but still have a portal or a view.

David Lansky – Pacific Business Group on Health – President & CEO
I'm having a little trouble sympathizing, going back to what the Meaningful Use Workgroup proposal is, we viewed the objectives that patients can view and download information and get discharge instructions. We've gone into a track of discussing the various either minimum or required or limiting technologies. From an IE point of view, the viewing part is sort of a non-issue for us. We endorse the requirement that data be viewable, which is already expressed in the Meaningful Use recommendation.

I think we're primarily speaking to the question of data portability and exchange in our Workgroup and I hear Paul endorsing that and Deven taking it as a given. Is our concern, since we don't really want to

prescribe technologies, unless some of us are thinking we need to say there are safer and less safe technologies and we want to provide guidance on that subject.

Paul Egerman – Software Entrepreneur
Right, but if the issue is the download in how that works, again, PCAST's letter suggested two alternatives. One would be the patient would push a button when they view the data and it described a structure by which the data would be transmitted to the patient and the other approach is the patient would put in probably like an e-mail address into something in the portal and using the Direct Project the information would be communicated directly to the EHR system using that address.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
All those are options and I think the goal is not to restrict the options, but on the contrary to offer various options to various individuals. Some people might not even know what is a Web portal or where do I go to buy one? Or some people might not know what a USB is or how to use a USB or some people might not even have an e-mail address.

Deven McGraw – Center for Democracy & Technology – Director
Yes, but, Walter, it's not about creating an unlimited set of options for doing this in my view because some options don't, in fact, from a functionality perspective; not all options are equal. Part of why I don't want to leave this open is because I want the technical capability to be part of certification. And if we don't describe with some level of detail what we're looking for, and maybe we don't say portal, but the ability for a patient to electronically view and download may be sufficient to describe it.

But the way that it's worded now it's open-ended and it leaves, I think, too much optionality for how those choices are made that doesn't necessarily meet the original goal of the Meaningful Use criteria.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
But the Web-based portal is not part of an EHR. And you're trying to force it to be part of an EHR.

Paul Egerman – Software Entrepreneur
I don't understand why you would say that.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Well, Web portals are used for many different purposes not just to access the medical information. So, providers use Web portals for many other things, like making an appointment. That's something that's no an EHR.

Paul Egerman – Software Entrepreneur
A portal can be used for many purposes, that's true. But we're putting forward the idea that within certification there would be a minimal use of portal that would allow a patient to view at least a summary, a CCD or a CCR type summary of their own record.

And we're not saying that they'd be able to make appointments or enter data or renew prescriptions or pay bills or do some of the other things that sometimes people do with these portals. The first step is very limited. It's just a view by the patient into their record, which has a lot of other benefits, incidentally, because the letter talks about medication reconciliation, but if patients start to have more and more access to their data that will motivate providers to sort of clean up for company. They'll have to start to fix these things because patients will start to point out either errors or omissions.

M
I just think we're being way too prescriptive. I prefer the open.

Deven McGraw – Center for Democracy & Technology – Director
Well, you know what? Then what this letter has to say is that there is a difference of opinion in the Information Exchange Workgroup about whether it should be prescriptive or left more open.

David Lansky – Pacific Business Group on Health – President & CEO
Yes, I think where you were going earlier, Deven, around identifying two or three issues that we want to advise both the Meaningful Use process and eventually CMS to be attentive to, is the best solution we can achieve right now and we don't want to limit technology, evolution and availability. We do want to make sure the burden on providers is manageable. We want to have the capability to the extent possible built into the technology.

We've heard the last couple of comments about the benefits of a portal as an effective minimal requirement, that that portal like capability be universal, but there are obviously some people in this Workgroup that don't want to restrict the modality of the delivering the view and download to just the portal.

What I haven't heard clarity about is whether we think a minimum requirement of a portal is a bad idea. So, if some eligible professionals wanted to just use thumb drives and not have a portal, we would oppose that or we--

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Well, I wonder, David – this is Micky – if we're saying that view and download are the two things we want to enable and that really don't, from a policy perspective, can't we sort of address some of Deven's concerns by saying that there are certain policy perspectives that we want to make sure are guiding what view and download mean? That there is a security aspect that cuts across all of that that's a requirement regardless of the medium and that there is a certain type of functionality with respect to both ease of provider workload as well as providing solutions that are actually feasible to consumers in the market.

And perhaps, and I don't know how far, from a policy perspective we go and what gets handed over to the Standards Committee to work out is there a set of standards related to content and nomenclature and all of that that we want to be able to say something about as well.

I think, if I'm understanding it correctly, those seem to be the things that Deven and Paul are concerned about, not necessarily the medium. The medium seems to be just about saying well here's an example in the real world of how that may work and address some of these concerns.

Paul Egerman – Software Entrepreneur
I just want to say, I am concerned also about the medium. The idea of doing this with the thumb drives, it's just not going to work. It especially is not going to work when you get to the next screen when you talk about discharge instructions.

The benefit of having discharge instructions be viewable and downloadable is that care givers can have access to it. You know, my 95-year-old stepmother is discharged from the hospital and she lives 3,000 miles away and I need to have access to the discharge instructions for some reason or another, the thumb drive doesn't really help me if I'm involved with her care.

And to certify systems around that it be viewable, that we define the terminology in the transport mechanisms, those things are very doable. As I say, we've actually laid out the options. Those are very doable items.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Well, wait, Paul, are you saying, without getting into the discharge instructions, you're saying that the discharge instructions will be viewable by not just the patient, but many other caregivers?

Paul Egerman – Software Entrepreneur
Well, I would think so.

Deven McGraw – Center for Democracy & Technology – Director
Yeah, with the patient's permission.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Okay.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I don't disagree necessarily with what Deven said when you explained your perspective there. As a matter of fact, I think many providers, if certification required the commercial EMR vendors to provide portal functionality such that I could just hand a patient in my office a piece of paper that says go to this URL and follow the instructions the vendor has there and you can have access to your information.

Or, if you give me an e-mail I'll put it in your file and then when your care summary is ready you'll get an automated e-mail that just says in a secure e-mail your care summary is ready. Click on this link. I think every doctor would just tell patients – not every, but many would just say if they want it on a thumb drive or a CD-ROM or something say, no, you don't have that option. Just go to this portal, that's how you get it.

Deven McGraw – Center for Democracy & Technology – Director
Yeah, and then they can put it on a thumb drive.

Paul Egerman – Software Entrepreneur
I have to jump off to do another call. I agree with what Steve just said.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Thank you, Paul. I just think we should have some language that says that there is some need for flexibility so the system can remain adaptive. I don't have a problem if we want to say the preferential thing is the minimum EMR vendors do certification should be required to offer portal functionality. I don't have a problem with that.

I guess all I was saying was I don't want to box us out of future things because if you rigidly say it must be done this way, then the whole lemmings are going to go that one direction and we may foreclose some other options down the road. I'm not with the thumb drives.

M
Agreed. I just don't think we ought to remove the possibility.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right. Does this get back to David's original postulation here, that do we want to say that a portal is minimal capability, but there is flexibility in terms of what else could be offered?

Paul Egerman – Software Entrepreneur
I'm fine with that. I think a portal is a reasonable current technology requirement.

Deven McGraw – Center for Democracy & Technology – Director
Yeah.

Paul Egerman – Software Entrepreneur
And maybe some environments we can't anticipate. There may be a lot of people who want to use something else for whatever reason, but the portal will be there as a back up and it will be a product.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I mean, again, the part that I raise as a concern is extending the definition of an EHR to cover Web-based portal capabilities. The next thing we'll be looking at is extending an EHR to e-mail capabilities and to social media capabilities.

David Lansky – Pacific Business Group on Health – President & CEO
That is the purpose of this category of engaging patients is to force the product, or at least the users, into having an array of products, which do offer that capability.

Deven McGraw – Center for Democracy & Technology – Director
That's right, I would agree.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
And I think the market is headed that way anyway. All the major EHR vendors certainly have this capability.

David Lansky – Pacific Business Group on Health – President & CEO
And we don't want to be tolerant to the EHRs that are strictly in clinic functionality, or at least don't have the interface to some module that supports this functionality. Let's try to move on. It sounds like we have almost a consensus, which is the idea that the portal is identified explicitly as a requirement and we note that other modalities should be allowed in addition to the portal, but those new modalities, in particular, should be sensitive to several issues we've talked about.

Deven McGraw – Center for Democracy & Technology – Director
Right, which does provide the flexibility in terms of when you're meeting the actual Meaningful Use criterion, such as the requirement to provide discharge instructions; you could meet your goal or your target percentage by using a variety of mechanisms, but at a minimum you have a portal functionality in your certified EHR that you can rely on.

David Lansky – Pacific Business Group on Health – President & CEO
That's a very good distinction and I don't know where the workgroup this morning came out, George, if you do; there was some debate on the list of topics as to whether the change the discharge instructions item, for example, to a percentage of patients not just offered, but provided. Has there been any resolution on that?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
No.

Deven McGraw – Center for Democracy & Technology – Director
Do you want to take that one, too?

David Lansky – Pacific Business Group on Health – President & CEO
No, but it does speak to your point, Deven, that the standard becomes provision to some proportion of patients and we don't need to be prescriptive about the mode used to provide it. We're not there yet, so let's just stay with what we've got and give this advice to the other group and let them sort it out.

All right, so Med Rec is the next topic up. I don't think we have significant new comments, unless someone tells me otherwise over this last week. So, let me just ask if the language in the draft letter is still adequate?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Which are you in?

David Lansky – Pacific Business Group on Health – President & CEO
Med Rec, the next item on the letter where the Med Rec, two paragraphs.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I want to thank you. The first sentence says it all; this is a very complicated process and so when you get to the second paragraph with what you recommend I think that's about as far as we can go at this point and so I think you've got it okay on this one.

David Lansky – Pacific Business Group on Health – President & CEO
Compliments then to Cory and Claudia. And so if there's no further discussion, we'll just move on.

M
And you're in the 4/28 version of the letter, right?

David Lansky – Pacific Business Group on Health – President & CEO
I just took the one off the most recent e-mail from Judy.

M
Yeah, 4/26 is what's on mine; 4/26 Buehler comments.

M
Yeah, I see two of them in the download section of the Webcast.

David Lansky – Pacific Business Group on Health – President & CEO
No, it's not the Buehler comments one, it's the 4/28 version. So, back to the question, are we okay moving on? Hearing no objections, we are moving on.

M
Yeah, quick, before anyone opens up the right version.

David Lansky – Pacific Business Group on Health – President & CEO
Our next issue is far more complex, which is parsing out of the old perform a test notion, which no one wants to sustain, but that everyone, I think, has agreed in principal we would rather identify a specific set of exchange functions, which could be assessed at Stage 2 and Stage 3, but I confess to my own confusion in the proposed Stage 2 and Stage 3 table that was put out for comment by the Workgroup, Meaningful Use Workgroup, there were some capabilities that were proposed for Stage 3 with no real transition during Stage 2.

Some of the Stage 2 requirements were really enhancements of the threshold of Stage 1. We are, in this letter and the draft letter currently in front of us, we are suggesting this test bed approach for those capabilities, which would be sought in Stage 3 so that people can get ready in a non-production mode.

We also acknowledge there are some environments where people don't have trading partners to execute the desired functions that are recommended for Stage 2 and therefore for those who might not have an operating environment in which to do these things the test bed would provide a way to demonstrate you have the functionality when your community is ready to support it, for example with Public Health Data Exchange.

But there have also been some objections about the proposal to use a test bed approach, either that it doesn't go far enough because we don't specify the actual functions we really want to see in use and hold people to those and then there is secondly this issue of the states versus national standards for some of the elements.

So, let me see where people are at the moment with the how do we get rid of perform a test question? And I will say that I am hoping that from George's comment that the Meaningful Use Workgroup work of this weekend might help solve this problem by proposing a more specific set of tests for care coordination and patient engagement that would be achievable for the vast majority of meaningful users and would advance the IE goals that we have. But, having not seen those proposals yet, I'm not sure if that's the case.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Well, David, actually no. The focus is away from any testing to actually having objectives that demonstrate the system rather than a test of the system. And, in fact, the weekend people are patient engagement and public health, not care coordination, which is where this objective would have been.

David Lansky – Pacific Business Group on Health – President & CEO
So, are the care coordination goals that were reviewed from David this morning, would they satisfy our thirst? I think we share the same objectives. We don't want to have these tests. We want to have real meaningful exchange.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I think it still needs to be cleaned up, but we talked about basically the care summary, trying to make that take the place of the test. Deven, you were there, too. So, basically turning it into the care summary recommendations taking the place of the test objective.

Deven McGraw – Center for Democracy & Technology – Director
Oh, absolutely, yes. And potentially also the objectives to set up an exchange deal with three people.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Replacing that.

Deven McGraw – Center for Democracy & Technology – Director
Yeah.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I thought they were not going down the replacement of the requirement to have three external providers be connected.

Deven McGraw – Center for Democracy & Technology – Director
Again, nothing was finalized on the call, Walter, but that was not my impression at all. It doesn't sound like it was George's either. I think the workgroup got to a place where they were comfortable with focusing the exchange requirements for Stage 2 on actually meeting other Meaningful Use care coordination criteria, such as the need to share a summary of care for transitions and referrals and to make a certain portion of what is right now a requirement to share that you could do in paper to meet a minimum electronic sharing requirement and then, of course, how the provider shares, whether it's using NHIN Direct protocols, whether it's through an HIE, would be up to them, and then we will probably have to include some exceptions for providers who because they don't have broadband access or other acceptable reasons just physically cannot meet the electronic exchange aspects of that.

But where we were heading by the close of that discussion was to absolutely eliminate just do a test, which, quite frankly, has never been on the table for Stage 2; that's a Stage 1 requirement, but to the extent that earlier versions of the Meaningful Use graph said connect with three providers electronically or do an HIE, that is being replaced with an exchange requirement that actually is about care coordination.

David Lansky – Pacific Business Group on Health – President & CEO
Deven, in general, I think the limitation has been a lot of that will still push and it wasn't really two-way coordination and it wasn't receipt of transmitted records; it was just sending records.

Deven McGraw – Center for Democracy & Technology – Director
Yeah, although one could argue that two-way communication is a push on either end, so we might not have query functionality necessarily, but if you already have a Meaningful Use obligation to push a care summary as part of a care transition or a referral then we want you to start pushing that electronically, unless you physically cannot.

David Lansky – Pacific Business Group on Health – President & CEO
So, I think you're saying that when push comes to shove we call it an exchange.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Yeah, the problem is, David, that whether it's push or pull, that first objective, which is that talk to three people, like you don't even know what you're talking about, so whether it's push or pull probably doesn't matter. It's an empty transaction and I guess the Workgroup felt that there should be some content in the

transaction and that the care summary was the most logical first content, and then the discussion went into well, how should we measure it? Should we say how many people you talk to or how much of your transitions are covered?

And the group leaned on the side of what percentage of your transitions was covered rather than how many people you talked to. And if it were how many people you talked to, some people were arguing for only one anyway, which might not have made me happy anyway.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I can serve this a little different, I think, and most of the things on the current draft letter of ours are around acquiring the data that's being sent to you, potentially then returning it and having bi-directional exchange whether it's getting back immunization records or getting back public health alerts, whatever it might be that it comes back in a form that can be accessed and used and then incorporated into the EHR.

It sounds like if the share a summary record moves to share a summary record electronically there is no particular prescription around what the receiver does with it.

Deven McGraw – Center for Democracy & Technology – Director
Right, but that wasn't necessarily part of how we were envisioning the requirement to set up exchange with three providers necessarily either. So, I think you were probably reading a little bit more into what would have been required to meet that, but I do think actually you raise an important point that we could put on the agenda for Stage 3, that what you really want is the bi-directional data flows and you have to get to that in Stage 3.

Or tee it up for Stage 2, but I think ideally in the context of something that actually would per one of the other Meaningful Use objectives be something that could and should be shared bi-directionally versus creating this sort of process exchange requirement that isn't linked to something that actually we want to see occurring in healthcare. I'm not sure that made any sense.

But I think the other thing that people didn't like about the previous requirement that was framed in terms of establish exchange with three people or connect to an HIE was that you could do that and then never send any data. So, we wanted it to be about what are actually the exchange transactions that we want to have happen and let's focus on making sure that those are electronic or whatever percentage of them we think we should make as a threshold matter for Stage 2 and then in terms of bi-directional exchange, if we can find a transaction that we want to push to be bi-directional, I think we should do that. Otherwise, we might try to scope out what that would look like for Stage 3.

Seth Foldy – Wisconsin – State Health Officer
I'm going to hold off on any discussion of the public health bi-directional exchange for now, but it seems to me that perhaps the use case we might want to talk about for other forms of back and forth exchange, the need for a query, would be, for example, the medication reconciliation process.

Sharing a patient summary seems to me to be a uni-directional push as a fairly decent way to do that, but being able to determine who has prescribed which medications at a variety of sites distinctly requires some kind of pull before it will be meaningful since you can't always know every place a patient has been. Am I missing something here?

David Lansky – Pacific Business Group on Health – President & CEO
I like the direction you're going of identifying one or more areas where we think IE needs to progress and adds a lot of clinical value.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
We should be clear of bi-directional meaning query response, right, not push push?

Carl Dvorak – Epic Systems – EVP
Just having done this for many, many years I'm still astounded at the confusion around the terms of bi-directional push versus pull query response. I wonder if we might want to ask someone to take some time and define some new concepts that better encapsulate the real issues at hand.

There is the ability to send an unsolicited summary to a third party and I think there is the ability to respond to requests for a summary from a third party and we might do well for the country to come up with a different set of terms. All exchanges are bi-directional, right? There's an AC and a MAC and a handshake and all that sort of thing. I think we need to better characterize this so patients can understand what's really happening at some point.

Seth Foldy – Wisconsin – State Health Officer
I do concur; we constantly stumble over it. I guess it seems to me that the two situations, and I apologize I'm going to try and think my way through this and if you think I'm confusing the issue just shut me up right away. There is the issue where, so for example, there is the situation of the immunization registry. A patient is in your office. You might do a shot and send the record to the immunization registry. But you might also want to pull the information about other vaccines from that immunization registry into your view somehow. Is that truly bi-directional?

In a sense the first is a push message and the other is a query operation. In that situation you have an immunization registry, which is already a repository or, if you will, a centralized HIE that people are making queries of.

So, now let's turn to the other situation where you're seeing a patient and you want to know what other medications have been prescribed by what other providers. Again, you're going to have to do a query of some kind of repository of either documents or messages or whatever to be able to obtain that information.

And I guess the reason patient care summaries was also included in this category is if you've seen a patient before and you don't know where they've been you want to do a query of patient care summaries that have been produced by other providers as well.

So, maybe we are over-complicating it by trying to make distinctions between these activities.

Deven McGraw – Center for Democracy & Technology – Director
I think the ability to query and look for patient records is the sort of technical functionality that we're not so sure exists well in the country. Clearly, there are some HIEs that have this down and are doing it, but other places do not, so we are talking about, and I totally get Carl's point and maybe it gets to the heart of what David really means when he says bi-directional exchange, but I think that we, certainly in the Meaningful Use Workgroup were focused around data holders sending out electronically.

In the case of the care summary it would be a care summary and whether that occurred because it was unsolicited and so, say, with respect to a care transition the referring physician knows the patient is heading in that direction, but, in fact, the referee, the referalee, the person who is getting the patient doesn't maybe know that the patient is coming, but they send the data in advance. Or, it is, in fact, in response to a particular request for data that then gets sent, we have a decent amount of capacity out there we think to be able to accommodate a transaction that the data holder can send once the data holder knows that the information is either wanted per a request or the data holder is sending it of his or her own accord.

I'm going to look for all the information that I can on this patient except if you've got care anywhere from Epic, maybe you can do that. I haven't seen a demo of that yet or you're involved in an HIE that allows you to do that, then you have some of that capacity, but it's not as widespread as we'd like it to be.

David Lansky – Pacific Business Group on Health – President & CEO
Let's see if we can come back to the short-term task that we have in the next few minutes, which is what to do about the comments to the Meaningful Use process, which is, obviously, in flux itself. So it may be that the Meaningful Use Workgroup is going to be recommending in the next few days something quite different from where they were a week or two ago.

We could remove this section from our letter for now and come back to it at some later stage in the discussion. We could try to distill a few thematic comments from some of what Steve said and what Carl said and put it in this section of this letter and simply take out; there is still some question about Stage 3 in the Meaningful Use Workgroup proposals that has some ambitious data exchange functionality and there is no particular pathway to get there, but that's not our immediate problem.

We may need some additional work on our own in the next few months even on what we think the desired state of Information Exchange should be by Stage 3 and whatever transitional steps we think are appropriate.

Seth Foldy – Wisconsin – State Health Officer
I will say the letter language left me very confused.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes, I think the letter language on the perform a test of HIE should be removed. I think it's just confusing and not directing necessarily the Meaningful Use Workgroup to do concrete things or clear things about Stage 2. This is more a Stage 3 direction, so I would support dropping this part.

We already submitted a strong recommendation on Stage 2 HIE, so I think, again, this second letter at this point just talks about more of a Stage 3 test bed kind of a situation.

David Lansky – Pacific Business Group on Health – President & CEO
So, is there a consensus that we all agree that to the extent the process can identify some specific exchanges, which are expected as part of Stage 2, we support that and we get rid of the test framework and we will continue to work with the Meaningful Use Workgroup on whatever those proposals are for the specific sustaining functions.

Carl Dvorak – Epic Systems – EVP
Can I ask a question on the text on the version I'm looking at, which is the 4/28 version it moves into the suggestions for Stage 2 to 3 requirements? As we look at forcing now the technical requirement of EHRs to exchange data with PHRs I worry that we haven't really worked through sufficient privacy on that. I wonder if what we could do is to say where PHRs support a minimum level of acceptable privacy and the organizations have full disclosure with patients as to any revenue share advertising kickbacks.

I think there's still a concern with many, many of our sites about they're being forced into advertising-based portals and one of the suggestions we got recently at a forum was when the provider pushes that PHR data out, could we have an agreed upon standard where that date might be marked to the patient's discretion as never for use with advertising and never for use with secondary purposes without express consent from the patient? And to include that in the standards making so that we don't unleash this without patients truly understanding what is likely to happen with their data and what their rights might have been with that data.

The worry is that we're going to force providers in a haste to do this and they'll shotgun it out to many, many portals that actually use the data for considerable list of secondary purposes in advertising.

David Lansky – Pacific Business Group on Health – President & CEO
Well, as I've said, there's a very large body of work Deven's been instrumental in for the last five years or so on this kind of question and it's probably more than we can tackle at the moment. It's a fair question. I think the question of having a policy framework within which this data is exchanged is really valid and important, but we may want to note it here that as simple as the first way you framed it initially, to prevent

or encourage data exchange with PHRs it has to be in an explicit, well understood policy framework, which goes through the normal policy process.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
We only have one sentence on this exchange with PHRs and we don't elaborate on it at all. So, if I'm understanding correctly we're going to drop this whole section so that it's not even going to show up? Is that what I'm understanding that we're going to do with the letter?

Carl Dvorak – Epic Systems – EVP
I don't know.

David Lansky – Pacific Business Group on Health – President & CEO
As I said, I had a concern that the Meaningful Use proposal that was from public comment has some Stage 3 proposals in it, including a PHR data exchange. The industry has asked that the process be more explicit about Stage 3 so that people have a good signal about what's coming. So, I don't know that we want to ignore Stage 3. On the other hand, this does open up exactly the kinds of questions Carl just listed if we start commenting on these Stage 3 proposals, which I think is actually appropriate to our particular charge because that's when exchange really hits the road. But we haven't had the time to fully vet these questions, certainly by today.

Carl Dvorak – Epic Systems – EVP
And I think we're in a very comfortable zone when it comes to HIPAA covered entity or a business associate intermediary that might exist between the two. I think as we look at the world of PHRs external to a health system provided PHR, they fall under an FCC rule set, or FTC rule set. That's just entirely different. We may want to contemplate that fully before putting these requirements in place.

Deven McGraw – Center for Democracy & Technology – Director
Which I think, you know, again, these are sort of scoped out for Stage 3 and I get that industry would like to know earlier rather than later what's on deck for Stage 3 and I don't mind in a general way raising the concerns. I kind of thought that we had done it in the generic way that this was already phrased.

I seriously doubt that given the time constraints that we're working under and the fact that we need to have what we're saying on Meaningful Use largely wrapped up by June. I don't know that there will be a lot of time to flesh out Stage 3 criteria like this one.

If we feel like we want to mention it given that there is a desire to do as much as we can on signaling what's going to be in Stage 3 as we possibly can, I don't have a problem with it as David just framed it raising that there are policy issues that would need to be resolved if we are going to either expressly or tacitly encouraging people to share data in PHRs that are not covered by a privacy framework and that we should only do so when one is in place.

I wouldn't want to dive into the level of detail that Carl is suggesting without a lot more time to chew on it.

Carl Dvorak – Epic Systems – EVP
Yes, and I think the struggle that I've got, Deven, in looking at this is if we establish a test bed implicit in that is that we figure those things out, so I struggle to understand how we would set up a test bed before we set the policy or fully understood those things. So, I would advocate for taking it out and if we'd like to add an intra-milestone by which ONC will have defined and set rules with sufficient lead time to Stage 3 we could make a recommendation that with regard to a certain set of items that we'd ask ONC to create an interim date for guidance on very specific and finite things.

The other one, and I don't know who wrote this section, but whoever got into the record a longitudinal care plan, very nice work because they really did hit on a lot of the complexity that sits behind that simple statement. That's another one that I couldn't even imagine a test bed being up and operational by Stage 2 for something like that. That's going to be extraordinarily complicated, or trivial. It depends on how it

was approached, but to do a fully shared, multiple author care plan across unaffiliated sites is a very daunting thing to even contemplate.

David Lansky – Pacific Business Group on Health – President & CEO
Given our time is so short now, I think we have agreement, unless I hear otherwise, of removing this section, the perform a test of HIE, roughly a page that would go away. I haven't heard clarity yet whether we want to replace it with some short comments about these other issues or simply wait until we see what the Workgroup comes up with in its current discussions and we'll, obviously, look at that when the time comes.

Carl Dvorak – Epic Systems – EVP
It seems that the issue that we're discussing right now is almost entirely a Stage 3 issue and we could table it for a future meeting. Am I wrong about that?

David Lansky – Pacific Business Group on Health – President & CEO
No, I think that's right. I think the question in my mind is what has to happen in Stage 2 for us to succeed with Stage 3? If a pre-typeable longitudinal care record ends up in the Stage 3 notes and we have no proposal for Stage 2; it's just going to come down from heaven to Stage 3, but we can assume there are other processes to deal with that.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I think my sense is our priority should be at this point of Stage 2, which is the one that needs to be defined in the next month. I think we will have a chance to later on look at the Stage 3 and see what needs to be adjusted about Stage 2 because of a Stage 3 requirement. But I think there's still a question about even what Stage 2 should be.

So, I think we will have time later on to review Stage 3 rather than highlighting it here in the letter without having a chance to fully vet each of the statements.

David Lansky – Pacific Business Group on Health – President & CEO
All right. Let's move on. I think we have no dissent at least for removing this section and let's go on to the reportable labs and public health button, which I think is mostly new material since the last time we all spoke.

I think, Seth, you may have had some additional comments since this was drafted?

Seth Foldy – Wisconsin – State Health Officer
So, I think actually the language that I think was part of the letter at our last meeting and that is reflected primarily in the March 28th letter you'll see a few what I believe are just wording clarifications, using tracked changes, that I've also added, but I've not really changed the sense.

So, what it reflects is a lack of consensus about whether it makes sense to move eligible provider laboratory reporting to the menu or core set. And that lack of consensus partly relates to how valuable versus how costly this would be. In my language I've also left open the idea that some of us believe that it might make sense for providers to attest that their private labs are submitting information the way some hospitals are likely to do so.

But basically it says we're not really reporting on a consensus on this element and it explains why. I'm going to hold off on Jim Buehler's comments until after I describe what we've done here. Then it does talk about the fact that adding the term "and conditions" is a little confusing; that we suggest that reportable conditions be considered in a way a slightly different element than laboratory results, but that we support in Stage 3 moving to a standard of creating at least some reportable conditions reporting from EHR to public health.

I don't know if there was a great deal of other comment on the letter language before we get to Jim's.

David Lansky – Pacific Business Group on Health – President & CEO
Let's stop there and see if people have any additional comments or if they're comfortable with the language that's here as description of the state of play.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I think this is consistent with actually the discussion this morning in the Meaningful Use Workgroup on this particular point. I think the recommendation to Art Davidson was to go back and work on a two-by-two matrix, basically, that looks at hospitals, eligible hospitals, eligible providers on the rows and then on the columns would be the lab reporting and then the case reporting and separating deliberately the two because in reality EPs, labs don't necessarily report on behalf of providers to the states.

They usually respond to state regulations that require the labs themselves to report those kinds of events. And then there is case reporting required on providers, in this case the eligible providers, that are separate from the actual lab reports, so I think this is consistent with the direction in which I think the group is leaning and it will be very helpful to give this to Art as he begins to think about the recommendations back to the Meaningful Use Workgroup.

Seth Foldy – Wisconsin – State Health Officer
And then I think the one thing that I did try and express is there are implementations of automated case reporting from EHR to public health, but no clear leading standard that would be ready for consideration in time for Stage 2. However, there is reason to believe that we could move to a reasonable model for other national standards by Stage 3.

So, if people are comfortable with this so far, and I'll wait for a second, before we move. I believe much of Jim's language was elaborating, adding more detail about the processes involved, but I do not know that he's challenging our statements. I believe that he is primarily adding more information about what's going on in the world today. I'm not certain that it's necessary, but I'll leave that for the group to decide.

I could make once change, perhaps, to reflect several lines of Jim's comment. And that would be where I had used the term, this is after the bullets and near the bottom of the paragraph, "Today's manual (paper) processes for such reporting." I believe if I added to that, "Today's manual (paper or Website entry)" I would have then referenced Jim's discussion about the fact that many states have Website form entry systems for this information. Have I lost everyone? I apologize if I did.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Which bullet is that?

Seth Foldy – Wisconsin – State Health Officer
These are not lined. So, if you look at reportable labs and public health button, the topic line, and you scroll down you'll see three bullets. Below those three bullets there's a paragraph and in that paragraph towards the bottom, there's a sentence that begins with, "Today's." I talked about manual processes as paper processes. Some of Jim's text points out that sometimes this means manual entry into a Website and what I'm proposing is that I would change paper to paper or Website entered and thus include that concept of his in our letter.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yeah, that would be fine.

Seth Foldy – Wisconsin – State Health Officer
And perhaps staff has already been able to do this and I won't need to. So, that way when we say manual processes we'll be including his talk about, "In today's world often infection preventionists and other are entering this data manually into Websites, not on paper forms." But are there larger concerns about the general direction?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
So, in summary, we're recommending number one, that reportable lab, which is being moved to core for hospitals, that's fine; that for eligible professional providers that now be the case that that stays as menu.

Seth Foldy – Wisconsin – State Health Officer
Actually, it's not currently menu. It doesn't exist at all now. In Stage 1 it is not a menu item for eligible providers.

David Lansky – Pacific Business Group on Health – President & CEO
So, the discussion is, George, the discussion was EH lab mandatory, okay. EP, forget lab, go straight to condition and make it a separate objective.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Make it a menu objective.

David Lansky – Pacific Business Group on Health – President & CEO
Well, we don't know if there is such a thing as menu in Stage 2, so it might be required, but it would be conditions, not lab.

Seth Foldy – Wisconsin – State Health Officer
We didn't reach a consensus.

David Lansky – Pacific Business Group on Health – President & CEO
Right, that's what the weekend is for. But just so that people know that there may not be any lab for EP; that was the controversial thing and we hadn't decided if there's such a thing as menu yet.

Seth Foldy – Wisconsin – State Health Officer
That's right. One argument that was made, of course, if every EP ahs to buy and EHR capable of sending electronic laboratory reports to public health, whether it's a menu item or a required item you still added that cost to the EHR systems of EPs. So, the way the letter is read is we did not achieve a consensus that it was a good thing to move electronic laboratory reporting to either menu or to core.

David Lansky – Pacific Business Group on Health – President & CEO
So, are there specific edits to the way the language in this draft looks, prior to the public health button reference? Are people ready to transmit it this way? Walter?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I'm fine with transmitting, and what we can do is Seth and I, we can just communicate that to Art.

Seth Foldy – Wisconsin – State Health Officer
I would be inclined to give Art Jim's language so he can have the benefit of it, but not necessarily as a Committee product, not necessarily as part of the Committee's official letter.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes, I think that works.

David Lansky – Pacific Business Group on Health – President & CEO
All right. Is there anything further on this reportable labs and public health section people want to modify? All right, let's go to the longitudinal care plan. I think Steve had made some comments earlier about feasibility for this, although it was well written. I don't recall if we had comments specific to this one. I just don't remember.

Seth Foldy – Wisconsin – State Health Officer
I thought it actually addressed one of the points that he raised, the concern that a multi-author care plan, very complex, even if it's very good, a single authored share, I think it kind of elegantly addressed the concern he raised earlier int his meeting. Is he still on?

Carl Dvorak – Epic Systems – EVP
This is Carl. I had mentioned that.

Seth Foldy – Wisconsin – State Health Officer
Carl, I'm sorry.

David Lansky – Pacific Business Group on Health – President & CEO
And we're simply raising questions here; we aren't posing a solution. Does anyone have any concerns about transmitting it in the current language with these proposed, provocative questions?

Deven McGraw – Center for Democracy & Technology – Director
No objection.

David Lansky – Pacific Business Group on Health – President & CEO
All right, we're rolling. List of care team members. I'm not clear from what George said earlier whether this is still maintained in the current discussion at the Meaningful Use Group or not.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Care team is still in there. It might be text for Stage 2.

David Lansky – Pacific Business Group on Health – President & CEO
It might be what for Stage 2, George?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Text. In other words, we're not quite there for 2013 to figure out the unique identifier for every provider, so it might be a text list in Stage 2.

David Lansky – Pacific Business Group on Health – President & CEO
And do most of the common EHR products currently support this?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I guess probably not; certainly not in any standardized or consistent manner.

Seth Foldy – Wisconsin – State Health Officer
And if you're talking about inside and outside your organization I would certainly guess not.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Yeah, I can speak for us, we have one, but what makes me suggest that many probably don't is that even those who have access to it don't quite know how to make use of it appropriately. You know, the notion of roles is not quite as well defined as one might presume them to be.

So, I do think there's an entire awareness that needs to be built about what does a care team really mean? Clearly, at a Kaiser they've got a crisper definition of it than at some other fee for service or hospital-based practice, where they're just one slice of it. So, I do think that is just a wide open new thing for most people to think about and deal with. Do people on this call have a sense of who their care team is when they get healthcare? I know I don't.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Well, mine is a team of one, which was part of the discussion this morning as I heard it, too. It was what if it's only one? Well, that's fine. What if that one is not a PCP, which is part of Meaningful Use Stage 2 requirement or expectation? So, what if my care team is really some specialist that is not a PCP, because that's the only problem I have right now.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I was even imagining it, well, you can imagine how weird I take things; I was thinking about the sanitarian inspecting the lead poisoned child's house, definitely information the doctor would like to know, but do we call that a member of the care team? I think so much needs to be defined here.

David Lansky – Pacific Business Group on Health – President & CEO
Right. So, in our text and I think the last paragraph, in particular, we say thematically what we just said. There's a lot to be done; it's a good idea, lots of work to be done to make it operational. I don't think from this discussion, we could add a few more bullet points to the list that was just mentioned, but I think in principal we've said what we have to say here.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I mean part of the question was whether this should be a Stage 2 or Stage 3. Right now it's a Stage 2, but are we going to be ready with all these questions by 2013 to implement this?

David Lansky – Pacific Business Group on Health – President & CEO
Well, I think if there's some cosmic agreement that it was just a text string with the names of some number of other providers, the answer may be different than if we have an elaborate requirement. Not knowing where they're going with that, it's hard to say.

I think from an IE point of view, it's worth our thinking a little bit, not today, back to our ILPD discussion, what are the implications of this subjective for provider directories generally and for their indexing, structured data fields, etc.?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Well, I think it's just; there are two aspects of the discussion there. One is the standardization and recording of the provider in a care team in a structured way, so whether it is a unique ID, an MPI or some other. But the other thing is really the workflow that has to be created in order to establish a recording of a care team list for every patient, for every care event that they are receiving care for.

So, I think those are two different parts and the first, the big problem in my mind is whether we would have enough clear understanding, even if it's only text. Whether we would have clear understanding of what is a care team? Who is a member of the care team and to what extent that includes everyone and that should be listed and communicated?

So, that's why I was raising it as a question of we agree that this should still be a Stage 2 or it should be more of a Stage 3. I don't know how people feel about that part, whether by Stage 2 we would be ready with all the definitions, all the understanding and all the workflows, and the EHRs will have the capability of recording all of this.

Deven McGraw – Center for Democracy & Technology – Director
These are the very same issues that the Meaningful Use Workgroup is sort of struggling over and so I don't think it's a bad idea to necessarily tee it up, although I don't think the Meaningful Use Workgroup thought about delaying it to Stage 3, but instead trying to find a way, assuming that it could be done from a technology perspective to sort of have a provider list that was manageable and doable for Stage 2.

George, do you think I framed that right?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Yes.

David Lansky – Pacific Business Group on Health – President & CEO
I think the implication for us, given our charge, less about whether what's doable and so on. It's what are the implications for the, for example, the Provider Directory work we've already done and thinking about an infrastructure that's going to support the fully realized version of this goal at some point in the future and not building an infrastructure through our Provider Directory work, which might somehow fail to

support this objective. But I could see leaving it pretty much as it and, perhaps, adding something along those lines. We realize there's an interface to the Provider Directory strategy that we want to be looking at down the road.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes, I think that would be important to include.

David Lansky – Pacific Business Group on Health – President & CEO
We're running out of time. Let me just see if there any other comments about this one or if people are essentially content with leaving it as a few guidance suggestions?

And the last section is the Stage 2 steppingstones for Stage 3, which we've pretty much discussed in our earlier discussion of PHR. I think we have two options here. One is to remove it because we're not talking about Stage 3 in this letter. And the other is to make a more generic comment saying, yeah, Stage 3 has some implications for Information Exchange that will need more work. We need a process to dig into that before too long.

Or we could leave it in.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I think the way it's worded is sort of generic, in my mind.

Paul Egerman – Software Entrepreneur
I have trouble with the way it's worded because I think we have answers for most of these questions for Stage 2. It might be easiest just to leave it out, but I believe there are answers for these questions for Stage 2.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
For PHR?

Paul Egerman – Software Entrepreneur
Absolutely. And I sent an e-mail response to David and Micky with the responses to the questions, assuming that we're talking about a one-way exchange; one-way from the EHR to the PHR. Then I think at least there's a minimal set of what you can do for Stage 2. Content and transport standards are defined and the source of information can be documented and if you have a concept of a portal, that is where the trigger can be. The patient can simply have a button on the portal where they request the transfer.

David Lansky – Pacific Business Group on Health – President & CEO
I think this is essentially a Stage 3 recommendation at this point in the discussion.

Paul Egerman – Software Entrepreneur
That's right.

David Lansky – Pacific Business Group on Health – President & CEO
I think it's reasonable for us to remove it from this letter for now.

Paul Egerman – Software Entrepreneur
And I don't have any problem, David, with removing it. I'm simply saying that there are answers for Stage 2.

David Lansky – Pacific Business Group on Health – President & CEO
I understand, Paul. I understand, rather in this last one or two minutes trying to get--

Paul Egerman – Software Entrepreneur
If we're out of time, that's not a problem.

David Lansky – Pacific Business Group on Health – President & CEO
I would propose, unless someone feels strongly, that we should keep it, in which case we'll need some other time to work it through. Or we take it out consistent the way we treated the previous perform a test section.

Paul Egerman – Software Entrepreneur
I'm fine with that.

David Lansky – Pacific Business Group on Health – President & CEO
Anybody want to advocate for keeping it? All right. So, let's just see if we have any big issues that people surfaced in the last week as they read all this that they think we've missed and we need to bring back into the discussion for this letter, second letter? All right.

Well, we'll check with Claudia and Cory, who may have other comments from other people on the Committee that we haven't talked about today and make sure we've got a full packet. But this should be enough material to reduce the scope and focus our comments for Stage 2 pretty well.

The last thing I think we have to do is see if there is any public comment.

Judy Sparrow – Office of the National Coordinator – Executive Director
That's right. Shall I check now?

David Lansky – Pacific Business Group on Health – President & CEO
Unless someone else has any other thing they want to put on the table. Let me just ask one more time? Hearing none, I guess we're ready for public comment and thanks, everybody, for your time today. It's been very productive and we got it to where we needed to get it.

Judy Sparrow – Office of the National Coordinator – Executive Director
Right, very good. Operator, can you please check and see if anybody wishes to make a comment?

Moderator
Yes. We do not have any comments at this time.

Judy Sparrow – Office of the National Coordinator – Executive Director
Okay, thank you all.

David Lansky – Pacific Business Group on Health – President & CEO
Thanks, everybody.